Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Fax 800-913-2229

Amerigroup
PA Pharmacy Phone 800-454-3730
PA Pharmacy Fax 844-512-8999
PA Medical Phone 855-201-7170
PA Medical Fax 855-363-0728

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929
PA Medical Phone 877-644-4623
PA Medical Fax 888-453-4756

UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328
PA Medical Phone 866-604-3267
PA Medical Fax 866-946-6474

Prior Authorization for Somatropin Products

Somatropin Products

(Genotropin®, Humatrope®, Norditropin®, Nutropin®, Omnitrope®, Saizen®, Tev-Tropin®, Zomacton®)

Beneficiary Information

Name: _____

Medicaid ID #: _____ Date of Birth: _____

Billing Provider Information (Pharmacy, Physician or Facility)

Name: _____ Medicaid ID #: _____

NPI #: _____ Phone #: _____ Fax #: _____

Requested Drug: _____ NDC: _____

Procedure Code Requested: _____ Total # procedure code units requested/time frame:_____

Prescriber Information

Name: _____ Medicaid ID #: _____

NPI #: _____ Phone #: _____ Fax #: _____

Clinical Prior Authorization for ADULTS

1. Prescribed by or in consultation with an endocrinologist? ☐ **Yes** ☐ **No**
2. Does the patient have one of the following:
   - ☐ Diagnosis of pituitary insufficiency confirmed by growth hormone stimulation test (< 5ng/mL serum concentration) and below normal IGF-1/IGFBP3
   - ☐ Diagnosis of panhypopituitarism including those with surgical or radiological eradication of pituitary confirmed by MRI or CT scan
3. Member has a perceived impairment of quality of life (QoL), as demonstrated by a reported score of at least 11 in the disease-specific 'Quality of life assessment of growth hormone deficiency in adults' (QoL-AGHDA) questionnaire? ☐ **Yes** ☐ **No** (Submit copy of questionnaire)
4. Is the somatropin product requested a non-preferred medication on the KS Medicaid Preferred Drug List (PDL)?
   ☐ **Yes –** complete Non-Preferred Medication on PDL section below ☐ **No**
   - Please note - For non-preferred medication requests the documentation must meet established clinical and PDL criteria to be approved. For requests for a preferred drug, then only the established clinical criteria must be met.

Clinical Prior Authorization for PEDIATRICS – ALL diagnoses – INITIAL APPROVAL

- ☐ Must include evaluation by a pediatric endocrinologist or pediatrician limiting practice to pediatric endocrinology
- ☐ Must include radiological evidence of open epiphyseal growth place (>16 for boys and >15 for girls)
- ☐ Diagnosis must be presented upon request

Additional Clinical Prior Authorization for PEDIATRIC Growth Hormone Deficiency (GHD)

1. Does the patient meet at least one of the following criteria?
   - ☐ Child has severe short stature with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex
   - ☐ Height more than 1.5 SDS below the mid-parental height
   - ☐ Child has moderate growth retardation with height more than 2 SDS below the mean and a height velocity over 1 year more than 1 SDS below the mean for chronological age, or a decrease in height SDS of more than 0.5 over 1 year in children over 2 years of age
   - ☐ In the absence of short stature, a height velocity more than 2 SDS below the mean over 1 year or more than 1.5 SDS sustained over 2 years
   - ☐ Child has decreasing growth rate combined with a predisposing condition such as previous cranial irradiation or tumor
   - ☐ Child exhibits evidence of other pituitary hormone deficiencies or signs of congenital GHD (hypoglycemia, microphallus, prolonged jaundice, traumatic delivery)
2. Does the patient have normal thyroid function tests (TSH 0.4-4.0 mIU/L)? ☐ **Yes** ☐ **No**
   - ☐ Documentation required
3. Does the patient have a failure to respond to 2 growth hormone secretagogues with peak <10ng/Ml? ☐ **Yes** ☐ **No**
   - ☐ Documentation required
   - ☐ MRI required for neonatal growth hormone deficiency AND those with peak <5 ng/mL
   - ☐ EXCEPTION: neonatal hypopituitarism/hypoglycemia where either GH peak < 10ng/mL during documented hypoglycemia is indication of GH deficiency OR documented structural abnormalities of the pituitary/hypothalamus (ectopic neurohypophysis, septo-optic dysplasia, or other midline defects)

Additional Clinical Prior Authorization for PEDIATRIC Panhypopituitarism

1. Does the patient have a documented deficiency of at least one pituitary hormone? ☐ **Yes** ☐ **No**
   - If **yes**, check all that apply:
     ☐ TSH ☐ ACTH ☐ LH/FSH ☐ ADH
   - Note: deficiencies in thyroid and cortisol must be treated before performance of the GH stimulation test
2. Include documentation or note values of response to 2 GH secretagogues:
   _____

   a. Patient must be on stable doses of other replacement hormones before performing stimulation tests.
   b. Normal thyroid levels documented before testing (TSH 0.4-4.0 mIU/L)
   c. < 5ng/mL = severe and < 10ng/mL = deficiency
   d. EXCEPTION: – neonatal hypopituitarism/hypoglycemia where either GH peak < 10ng/ml during documented hypoglycemia is indication of GH deficiency or documented structural abnormalities of the pituitary/hypothalamus (ectopic neurohypophysis, septo-optic dysplasia, or other midline defects). Deficiency can be documented by failure to respond to secretagogues but is not required

Additional Clinical Prior Authorization for PEDIATRIC Chronic Renal Insufficiency (CRI)

1. Does the patient have a confirmed diagnosis of CRI by a pediactric nephrologist? ☐ **Yes** ☐ **No**
   - ☐ Documentation required
2. Is the height velocity < 25th percentile for the patient's age? ☐ **Yes** ☐ **No**
   - ☐ Documentation of at least 6 months of growth data required
   - ☐ Documentation of growth curve required

Additional Clinical Prior Authorization for PEDIATRIC Turner or Noonan Syndrome

1. Does the patient have a confirmed diagnosis of Turner or Noonan syndrome by karyotype? ☐ **Yes** ☐ **No**
   - ☐ Documentation required
2. Does the patient have normal thyroid function tests (TSH 0.4-4.0 mIU/L)? ☐ **Yes** ☐ **No**
   - ☐ Documentation required
3. Is the height velocity < 5th percentile for the patient's age? ☐ **Yes** ☐ **No**
   - ☐ Documentation of at least 6 months of growth data required
   - ☐ Documentation of growth curve required

Additional Clinical Prior Authorization for PEDIATRIC Prader-Willi Syndrome (PWS)

1. Does the patient have a confirmed diagnosis of PWS by a geneticist? ☐ **Yes** ☐ **No**
   - ☐ Documentation required
2. Does the patient have normal thyroid function tests (TSH 0.4-4.0 mIU/L)? ☐ **Yes** ☐ **No**
   - ☐ Documentation required
3. Has the patient had a DEXA scan for body composition completed? ☐ **Yes** ☐ **No**
   - ☐ Documentation required
4. Does the patient have an absence of obstructive sleep apnea by sleep study or treated obstructive sleep apnea?
   - ☐ Absence of obstructive sleep apnea by sleep study
   - ☐ Treated obstructive sleep apnea
5. Is the height velocity < 25th percentile for the patient's age or height < 5th percentile? ☐ **Yes** ☐ **No**
   - ☐ Documentation of at least 6 months of growth data required
   - ☐ Documentation of growth curve required

Additional Clinical Prior Authorization for PEDIATRIC Small for Gestational Age (SGA)

1. Was the birth weight of the patient less than 2,500 g at a gestational age of more than 37 weeks? ☐ **Yes** ☐ **No**
2. Was the birth weight or length of the patient below the 3rd percentile for gestational age? ☐ **Yes** ☐ **No**
3. Did the patient fail to manifest catch-up growth to reach normal height range by age 2? ☐ **Yes** ☐ **No**

Additional Clinical Prior Authorization for PEDIATRIC Short Stature Homeobox-Containing Gene (SHOX) Deficiency

1. Does the patient have a confirmed diagnosis of SHOX by a geneticist? ☐ **Yes** ☐ **No**
   - ☐ Documentation required
2. Does the patient have normal thyroid function tests (TSH 0.4-4.0 mIU/L)? ☐ **Yes** ☐ **No**
   - ☐ Documentation required
3. Is the height velocity <25th percentile for the patient's age or height < 5th percentile? ☐ **Yes** ☐ **No**
   - ☐ Documentation of at least 6 months of growth data required
   - ☐ Documentation of growth curve required

Clinical Prior Authorization for PEDIATRIC Growth Hormone Deficiency (GHD) – RENEWAL

1. Documentation of the following is required:
   - ☐ History and physical notes and growth curve from pediatric endocrinologist dated within 6 months of request
   - ☐ Documented catch-up growth unless at target height percentile
2. Rationale for discontinuing GH therapy, is one of the following criteria met? (check all that apply)
   - ☐ Growth velocity < 2 cm/year while on GH therapy:
     - Is there persistent and uncorrectable problems with adherence to GH treatment. Compliance is defined as greater than or equal to 85% adherence to regimen (no more than one missed dose per week on average)? ☐ **Yes** ☐ **No**
     - Does the prescriber ATTEST to patient adherence? ☐ **Yes** ☐ **No** (Prescription claims data may be used to verify adherence)
   - ☐ Recommendations of treating pediatric nephrologist or endocrinologist due to changes in underlying conditions
   - ☐ If there is poor response to treatment, generally defined as an increase in growth velocity of less than 50% from baseline, in the first year of therapy. In children with PWS, evaluation of response to therapy should also take into account whether body composition (i.e., ratio of lean to fat mass) has significantly improved
   - ☐ Evidence of epiphyseal closure
   - ☐ Expected final adult height has been reached, as defined by reaching the calculated mid-parental height* or reaching the 25th percentile of the adult height based on sex**, whichever comes first

Non-Preferred Medication on PDL

Check the appropriate box and provide the required information if the requested medication is a non-preferred drug on the PDL.

☐ If there is one preferred agent in the preferred category, has the patient experienced an inadequate response after a trial of the preferred agent at a maximum tolerated dose, or do they have a documented intolerance or contraindication to the preferred agent?

☐ YES ☐ NO ☐ INTOLERANCE/CONTRAINDICATION

☐ If there are two or more agents in the preferred category, has the patient experienced an inadequate response after a trial of two or more of the preferred agents at their maximum tolerated dose, or do they have a documented intolerance or contraindication to two or more preferred agents?

☐ YES ☐ NO ☐ INTOLERANCE/CONTRAINDICATION

List previous medication trial(s) and date(s) of trial:

Medication Name: _____ Date(s) of trial: _____

Medication Name: _____ Date(s) of trial: _____

List medication intolerance or contraindication (if any):

_____

_

☐ An appropriate formulation or indication is not available as a preferred drug. Please specify which formulation or indication is needed and information supporting the need:

_____

Prescriber's Signature: _____ Date: _____

This form will be returned unprocessed if it is not completed in its entirety.